		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023309

Facility Name: Calvin Johnson Care Center

Address: 727 North 17th Street (Number) Belleville (City) 62223 (Zip Code)

County: St. Clair

Telephone Number: (618) 234-3323 **Fax #** (618) 234-9477

IDPA ID Number: 37-1024089001

Date of Initial License for Current Owners: 04/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Wayne Franklin **Telephone Number:** (618) 624-2157

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Steve Wolf

(Title) Executive Administrator

Paid Preparer

(Signed) See Accountants Compilation Report (Date)

(Print Name and Title) J. Wayne Franklin, Senior Manager

(Firm Name & Address) Blue & Company, LLC
125 Springfield Court, Suite #1, O'Fallon, IL 62269

(Telephone) (618) 624-2157 Fax # (618) 624-2159

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	186	Skilled (SNF)	186	68,076	1
2		Skilled Pediatric (SNF/PED)			2
3	51	Intermediate (ICF)	51	18,666	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,742	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,186	880	2,451	7,517	8
9	SNF/PED					9
10	ICF	44,489	9,351	882	54,722	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,675	10,231	3,333	62,239	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.75%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 48 and days of care provided 2,368

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,835	17,058	20,537	247,430		247,430		247,430			1
2	Food Purchase		313,000		313,000		313,000		313,000			2
3	Housekeeping	300,406	31,306		331,712		331,712		331,712			3
4	Laundry	102,132	11,069	18,016	131,217		131,217		131,217			4
5	Heat and Other Utilities			198,721	198,721		198,721	2,537	201,258			5
6	Maintenance	73,031	45,012	46,911	164,954		164,954	3,864	168,818			6
7	Other (specify):*											7
8	**TOTAL General Services**	685,404	417,445	284,185	1,387,034		1,387,034	6,401	1,393,435			8
	B. Health Care and Programs											
9	Medical Director			17,124	17,124		17,124		17,124			9
10	Nursing and Medical Records	1,735,580	176,356	56,469	1,968,405	(147,561)	1,820,844		1,820,844			10
10a	Therapy	87,337	389	68,555	156,281	(66,068)	90,213		90,213			10a
11	Activities	55,642	9,558		65,200		65,200	(6,187)	59,013			11
12	Social Services	68,860		3,137	71,997		71,997		71,997			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,947,419	186,303	145,285	2,279,007	(213,629)	2,065,378	(6,187)	2,059,191			16
	C. General Administration											
17	Administrative	167,939		62,290	230,229		230,229	(62,290)	167,939			17
18	Directors Fees											18
19	Professional Services			3,615	3,615		3,615	7,231	10,846			19
20	Dues, Fees, Subscriptions & Promotions			45,540	45,540		45,540	(26,400)	19,140			20
21	Clerical & General Office Expenses	288,316	13,386	47,674	349,376		349,376	13,115	362,491			21
22	Employee Benefits & Payroll Taxes			383,177	383,177		383,177	22,655	405,832			22
23	Inservice Training & Education			30	30		30		30			23
24	Travel and Seminar			6,066	6,066		6,066	2,790	8,856			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,687	32,687		32,687	246	32,933			26
27	Other (specify):* See Attached			15,351	15,351		15,351	(15,351)				27
28	**TOTAL General Administration**	456,255	13,386	596,430	1,066,071		1,066,071	(58,004)	1,008,067			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,089,078	617,134	1,025,900	4,732,112	(213,629)	4,518,483	(57,790)	4,460,693			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Line 27 Detail:

Contributions	$12,798
Sales Tax	$2,553
Total	**$15,351**

Facility Name & ID Number Calvin Johnson Care Center #0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			80,932	80,932		80,932	3,423	84,355			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,586	14,586		14,586	(3,357)	11,229			32
33	Real Estate Taxes			46,416	46,416		46,416		46,416			33
34	Rent-Facility & Grounds			644,302	644,302		644,302	8,088	652,390			34
35	Rent-Equipment & Vehicles			641	641		641	5,215	5,856			35
36	Other (specify):*											36
37	**TOTAL Ownership**			786,877	786,877		786,877	13,369	800,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					213,629	213,629		213,629			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			130,114	130,114		130,114		130,114			42
43	Other (specify):* **See Attached**			11,953	11,953		11,953	1,477	13,430			43
44	**TOTAL Special Cost Centers**			142,067	142,067	213,629	355,696	1,477	357,173			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,089,078	617,134	1,954,844	5,661,056		5,661,056	(42,944)	5,618,112			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Line 43 Detail:

Vending Machine Cost	$13,430
Income Tax Prior Year	($1,477)
Total	**$11,953**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(92)	30		9
10	Interest and Other Investment Income	(3,357)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,553)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(12,798)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(148)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(19,367)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(13,999)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (52,314)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,314)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	Medical Supplies	X		81,689	10-2	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		4,605	10-2	42
43	Prescription Drugs	X		61,267	10-2	43
44	Exceptional Care Program					44
45	Other-Attach Schedule Therapy	X		66,068	10a-3	45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 213,629		47

STATE OF ILLINOIS

Calvin Johnson Care Center

ID# 0023309

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (594)	21	1
2	Gift Shop Income	(259)	11	2
3	Activity Sales	(5,138)	11	3
4	Beauty Shop Income	(790)	11	4
5	Lobbying Costs	(3,090)	20	5
6	Income Tax Prior Year	1,477	43	6
7	Bookkeeping Fee Income	(803)	21	7
8	Out of State Seminar Cost H.O.	(255)	24	8
9	Chamber of Commerce	(475)	20	9
10	Public Relations	(4,072)	20	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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78				78
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83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(13,999)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,537	0	0	0	0	0	0	0	0	2,537	5
6	Maintenance	0	0	3,864	0	0	0	0	0	0	0	0	3,864	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	6,401	0	0	0	0	0	0	0	0	6,401	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,187)	0	0	0	0	0	0	0	0	0	0	(6,187)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(6,187)	0	0	0	0	0	0	0	0	0	0	(6,187)	16
	C. General Administration													
17	Administrative	0	(152,266)	89,976	0	0	0	0	0	0	0	0	(62,290)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(148)	0	7,379	0	0	0	0	0	0	0	0	7,231	19
20	Fees, Subscriptions & Promotions	(27,004)	0	604	0	0	0	0	0	0	0	0	(26,400)	20
21	Clerical & General Office Expenses	(1,397)	(112,369)	126,881	0	0	0	0	0	0	0	0	13,115	21
22	Employee Benefits & Payroll Taxes	0	0	22,655	0	0	0	0	0	0	0	0	22,655	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(255)	0	3,045	0	0	0	0	0	0	0	0	2,790	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	246	0	0	0	0	0	0	0	0	246	26
27	Other (specify):*	(15,351)	0	0	0	0	0	0	0	0	0	0	(15,351)	27
28	**TOTAL General Administration**	(44,155)	(264,635)	250,786	0	0	0	0	0	0	0	0	(58,004)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,342)	(264,635)	257,187	0	0	0	0	0	0	0	0	(57,790)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(92)	0	3,515	0	0	0	0	0	0	0	0	3,423	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,357)	0	0	0	0	0	0	0	0	0	0	(3,357)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,088	0	0	0	0	0	0	0	0	8,088	34
35	Rent-Equipment & Vehicles	0	0	5,215	0	0	0	0	0	0	0	0	5,215	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,449)	0	16,818	0	0	0	0	0	0	0	0	13,369	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	1,477	0	0	0	0	0	0	0	0	0	0	1,477	43
44	**TOTAL Special Cost Centers**	1,477	0	0	0	0	0	0	0	0	0	0	1,477	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(52,314)	(264,635)	274,005	0	0	0	0	0	0	0	0	(42,944)	45

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Steve Wolf	30	Eldercare of Alton	Alton	Eldercare, Inc.	Belleville	Nurs.Home Mgmt
Steve Wolf	50	Columbia Convalescent Center	Columbia			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17-1	Home Office Prorate	$ 89,976	Eldercare Inc.	0.00%	$	$ (89,976)	1
2	V	21-1	Home Office Prorate	112,369	Eldercare Inc.	0.00%	274,005	161,636	2
3	V	17-3	Home Office Prorate	62,290	Eldercare Inc.	0.00%		(62,290)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 264,635			$ 274,005	$ * 9,370	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance	$			$ 3,864	$ 3,864	15
16	V	17	Administrative				89,976	89,976	16
17	V	19	Professional Services				7,379	7,379	17
18	V	20	Fees,Subscriptions & Promotions				604	604	18
19	V	21	Clerical & Gen Admin				126,881	126,881	19
20	V	22	Employee Benefits				22,655	22,655	20
21	V	24	Travel & Seminar				2,790	2,790	21
22	V	24	Travel & Seminar Out of State				255	255	22
23	V	26	Ins-Prop				246	246	23
24	V	30	Depreciation				3,515	3,515	24
25	V	34	Rent Facility				8,088	8,088	25
26	V	35	Rent Equipment				5,215	5,215	26
27	V	5	Utilities				2,537	2,537	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 274,005	$ * 274,005	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Steve Wolf	President	Executive Adm.	30.00	252,674	19	38.00	Salary	$ 89,976	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 89,976		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Other Compensation Detail:

Steve Wolf

Columbia Care Center	$171,772
Eldercare of Alton	$80,902
Total	**$252,674**

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Eldercare, Inc.
Street Address: 2620 W. Blvd.
City / State / Zip Code: Belleville, IL. 62221-7208
Phone Number: (618 234-2273
Fax Number: (618 234-7777

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance	Direct Cost	10,749,136		$ 7,338	$	5,659,966	$ 3,864	1
2	17	Administrative	Direct Cost	10,749,136		170,878	170,878	5,659,966	89,976	2
3	19	Professional Services	Direct Cost	10,749,136		14,014		5,659,966	7,379	3
4	20	Fees,Subscriptions & Promotions	Direct Cost	10,749,136		1,148		5,659,966	604	4
5	21	Clerical & Gen Admin	Direct Cost	10,749,136		240,966	213,407	5,659,966	126,881	5
6	22	Employee Benefits	Direct Cost	10,749,136		43,026		5,659,966	22,655	6
7	24	Travel & Seminar	Direct Cost	10,749,136		5,298		5,659,966	2,790	7
8	24	Travel & Seminar Out of State	Direct Cost	10,749,136		485		5,659,966	255	8
9	26	Ins-Prop	Direct Cost	10,749,136		468		5,659,966	246	9
10	30	Depreciation	Direct Cost	10,749,136		6,675		5,659,966	3,515	10
11	34	Rent Facility	Direct Cost	10,749,136		15,360		5,659,966	8,088	11
12	35	Rent Equipment	Direct Cost	10,749,136		9,904		5,659,966	5,215	12
13	5	Utilities	Direct Cost	10,749,136		4,818		5,659,966	2,537	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 520,378	$ 384,285		$ 274,005	25

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Union Planters		X	Open Line of Credit	Demand	10/1994	100,000	95,727	11/2001	Variable	14,586	6
7												7
8												8
9	TOTAL Facility Related						$ 100,000	$ 95,727			$ 14,586	9
	B. Non-Facility Related*											
10				Interest Income							(3,357)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,357)	14
15	TOTALS (line 9+line14)						$ 100,000	$ 95,727			$ 11,229	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Calvin Johnson Care Center **#** 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	41,940	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,632	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,692	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	44,724	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,416	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	36,682	8
	1996	36,726	9
	1997	39,447	10
	1998	41,124	11
	1999	43,632	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,326 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	N/A				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Impr.			1982	600		10			600	9
10	1983 Audit			1983	4,085		10			4,085	10
11	Building Impr.			1983	49,553		10			49,553	11
12	Black Top			1983	1,033		12			1,033	12
13	Remodeling			1984	7,160	358	20	266	(92)	7,160	13
14	Landscaping			1984	3,604		10			3,604	14
15	Windows			1985	1,454		10			1,454	15
16	A/C System			1985	1,983		8			1,983	16
17	Canopies			1985	6,333		10			6,333	17
18	Sidewalk			1985	7,800	260	15	260		7,800	18
19	Driveway Sealer			1985	810		5			810	19
20	Parking Stripes			1986	524		5			524	20
21	Renovate Halls			1988	21,660		10			21,660	21
22	Renovate Baths			1989	14,042		10			14,042	22
23	Roof Remod.			1990	53,033	3,045	10-15	3,045		40,871	23
24	Remodeling			1991	51,920	3,164	5-10	3,164		34,550	24
25	Remodeling			1992	140,195	10,449	5-15	10,449		89,716	25
26	Remodeling			1993	52,694	2,432	5-15	2,432		18,567	26
27	Hall Monitor System			1994	3,208	204	15-20	204		1,372	27
28	Improvements			1995	27,040	2,785	5-15	2,785		16,353	28
29	Elevator			1996	6,729	449	15	449		2,020	29
30	Awnings			1996	4,195	420	10	420		1,785	30
31	Rooftop			1996	10,643	1,330	8	1,330		5,985	31
32	Renovations Paint/Wallpaper			1996	1,000	200	5	200		1,000	32
33	Air Cond. Work & Carpeting			1997	7,032	869	5-15	869		3,176	33
34	Fence			1998	1,250	156	8	156		468	34
35	Interior Renovation			1998	11,308	1,124	5-15	1,124		2,852	35
36	TOTAL (lines 4 thru 35)				$ 490,888	$ 27,245		$ 27,153	$ (92)	$ 339,356	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cubicle Tracks			1999	6,358	424	15	424	0	848	9
10	Light Fix, Water Htr, Doors			1999	22,799	2,280	10	2,280		3,420	10
11	Automatic Doors			1999	18,508	1,851	10	1,851		2,776	11
12	Tile & Wallpaper Halls & Dining room			1999	5,960	1,192	5	1,192		1,788	12
13	Cubicle Tracks			2000	14,481	483	15	483		483	13
14	Light Fixtures, Dining Room Doors, Awings			2000	12,015	601	10	601		601	14
15	Wallpaper and Carpet Halls, Nurses Station and Offices			2000	7,124	712	5	712		712	15
16	Landscaping			2000	21,212	529	10	529		529	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 108,457	$ 8,072		$ 8,072	$ 0	$ 11,157	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 371,135	$ 42,887	$ 42,887	$	3-20yr	$ 179,323	37
38	Current Year Purchases	57,476	2,298	2,298		3-15yr	2,298	38
39	Fully Depreciated Assets	126,036				FD	126,036	39
40	Home Office Allocation			3,515	3,515		N/A	40
41	TOTALS	$ 554,647	$ 45,185	$ 48,700	$ 3,515		$ 307,657	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Transportation	1971 Bus	1977	$ 4,339	$	$	$	3	$ 4,339	42
43	Facility Use	1989 Olds Wagon	1992	8,550				2	8,550	43
44	Lift for bus	Lift for Bus	1995	4,299	430	430		5	4,299	44
45										45
46	TOTALS			$ 17,188	$ 430	$ 430	$		$ 17,188	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,171,180	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 80,932	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 84,355	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 3,423	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 675,358	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Vending Machine 1980	$ 1,769	$	$ 1,769	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 1,769	$	$ 1,769	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59		N/A	59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: National Nursing Home, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1969	237	4/1/1977	$ 644,302	20	20	3
4	Additions							4
5								5
6								6
7	TOTAL		237		$ 644,302 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 04/01/97
Ending 04/01/02

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ CPI Index increase
13.	/2002	$ CPI Index increase
14.	/2003	$ CPI Index increase

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18		N/A			18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-3	hrs	$	90	$ 6,690	$	90	$ 6,690	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		100	6,943		100	6,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		76	6,748		76	6,748	4
5	Physician Care	10a-3	visits		10	1,250		10	1,250	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-2	# of prescrpts				61,267		61,267	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	10a-1	2080	44,437				2,080	44,437	12
13	Medical Supplies Other (specify): Lab/Xray/Amb.	10-2 10-2				4,605	81,689		81,689 4,605	13
14	TOTAL			$ 44,437	276	$ 26,236	$ 142,956	2,356	$ 213,629	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,184	$	1
2	Cash-Patient Deposits	74,468		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,345,736		3
4	Supply Inventory (priced at cost)	25,635		4
5	Short-Term Investments			5
6	Prepaid Insurance	66,338		6
7	Other Prepaid Expenses	72,775		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Notes Receivable Current	35,217		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,627,353	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	595,261		15
16	Equipment, at Historical Cost	573,604		16
17	Accumulated Depreciation (book methods)	(671,785)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 497,080	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,124,433	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 236,906	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	74,468		28
29	Short-Term Notes Payable	95,727		29
30	Accrued Salaries Payable	111,023		30
31	Accrued Taxes Payable (excluding real estate taxes)	47,508		31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,724		32
33	Accrued Interest Payable	1,576		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accruals	7,465		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 619,397	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Payable	896,196		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 896,196	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,515,593	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 608,840	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,124,433	$	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 538,112	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 538,112	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	70,728	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 70,728	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 608,840	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,331,775	1
2	Discounts and Allowances for all Levels	(20,840)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,310,935	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	116,520	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 116,520	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	259	12
13	Barber and Beauty Care	790	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	91,901	17
18	Sale of Supplies to Non-Patients	163,378	18
19	Laboratory	14,686	19
20	Radiology and X-Ray	3,022	20
21	Other Medical Services	20,215	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 294,251	23
	D. Non-Operating Revenue		
24	Contributions	186	24
25	Interest and Other Investment Income***	3,357	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,543	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Actvity Sales	5,138	28
28a	Bookkeeping Fees/Misc Inc	1,397	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,535	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,731,784	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,387,034	31
32	Health Care	2,065,378	32
33	General Administration	1,066,071	33
	B. Capital Expense		
34	Ownership	786,877	34
	C. Ancillary Expense		
35	Special Cost Centers	225,582	35
36	Provider Participation Fee	130,114	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,661,056	40
41	**Income before Income Taxes (line 30 minus line 40)****	70,728	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 70,728	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. Return on Extension**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,494	2,080	$ 47,266	$ 22.72	1
2	Assistant Director of Nursing	2,000	2,080	40,232	19.34	2
3	Registered Nurses	8,420	9,060	178,413	19.69	3
4	Licensed Practical Nurses	25,483	27,967	436,409	15.60	4
5	Nurse Aides & Orderlies	94,685	100,603	957,196	9.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,542	2,542	45,289	17.82	7
8	Rehab/Therapy Aides	3,945	4,245	42,048	9.91	8
9	Activity Director	2,000	2,080	24,597	11.83	9
10	Activity Assistants	4,488	4,813	31,045	6.45	10
11	Social Service Workers	6,402	6,762	68,860	10.18	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	24,230	11.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,601	26,077	185,605	7.12	15
16	Dishwashers					16
17	Maintenance Workers	7,410	8,078	73,031	9.04	17
18	Housekeepers	43,210	46,810	300,406	6.42	18
19	Laundry	12,412	13,530	102,132	7.55	19
20	Administrator	3,288	3,068	167,939	54.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	21,859	23,144	288,316	12.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) QA, Care Plans	4,710	5,135	76,064	14.81	33
34	TOTAL (lines 1 - 33)	271,949	290,154	$ 3,089,078 *	$ 10.65	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	503	$ 13,078	1-3	35
36	Medical Director	171	17,124	9-3	36
37	Medical Records Consultant	24	840	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,020	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	88	3,075	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	810	$ 35,137		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,926	50,517	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,926	$ 50,517		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Debra Ford	Administrator	0	$ 77,963
Steve Wolf	Executive Administrator	30	89,976
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 167,939

B. Administrative - Other

Description	Amount
Home Office Prorate	$ 62,290
TOTAL (agree to Schedule V, line 17, col. 3)	$ 62,290
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Flynn & Guyman	Legal	$ 1,127
Van Ostrand	Legal	2,340
SAMAS	Legal	148
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 3,615

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,557
Unemployment Compensation Insurance	31,414
FICA Taxes	221,852
Employee Health Insurance	49,431
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Empl Benefits	16,923
Home Office Payroll Taxes	22,655
TOTAL (agree to Schedule V, line 22, col.8)	$ 405,832

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 632
Advertising: Employee Recruitment	6,019
Health Care Worker Background Check	
(Indicate # of checks performed 210)	2,517
HCPA/CILA	350
Lobbying & Advertising	22,457
Community Notices & Public Relations	4,619
IHCA Dues	6,448
Publications & Chamber Dues	2,498
Home Office Dues & Fees	604
Less: Public Relations Expense	(4,547)
Non-allowable advertising	(22,457)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,140

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Home Office	255
In-State Travel	0
Seminar Expense	6,066
Home Office	2,790
Out of State Cost	(255)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,856

**See instructions.

Facility Name & ID Number Calvin Johnson Care Center # 0023309 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	Not Applicable												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Calvin Johnson Care Center # 0023309 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA 6448**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,445** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **130,114**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.